APPLICATION TO BECOME A PROVIDER OF CONTINUING EDUCATION

Instructions Required:

1. Submit in duplicate (photocopies accepted)
2. Please print or type
3. Check or money order for $150 must accompany application, payable to:
   NHAP
   P.O. Box 997416, MS 3302
   Sacramento, CA 95899-7416
   (916) 552-8780
4. Refer to Guidelines for Approval of Continuing Education Providers and Courses

FOR OFFICE USE ONLY

Cash # _____

Amount_____

NHAP Staff Initial_____

Name of Provider: _____ Phone No.: _____

Business Address: _____

SSN Acct. # or FEIN: _____ **(Provider certificates cannot be issued without this number.** Does not apply to partnerships.)

Provider is a/an:

❑ Individual ❑University, College, or School ❑Health Association ❑Partnership ❑ Health Facility

❑Corporation ❑ Government Agency ❑ Other: _____

Print below the name and title of: if an individual, the individual applying; if a partnership, the members thereof; if a corporation, association, or other type of organization, the president, vice-president, and secretary.

NAME _____ TITLE _____

NAME _____ TITLE _____

NAME _____ TITLE _____

Name, title, and mailing address of person to whom all correspondence should be directed:

NAME _____ TITLE _____

Signature: _____ Date: _____

Maintenance of the information requested on the application form is authorized by the Health and Safety Code. No items of information are voluntary; all are required. Failure to provide any of the requested information will result in the rejection of the application.

DO NOT WRITE BELOW THIS LINE

❑ Application has been approved. Provider #: _____ Approved by: _____

Date: _____ Approval Expires:_____

❑ Application has been denied. Denied by: _____ Date:_____

Reason for denial:_____